**Significance & Background:** Appropriate use of resources and reducing costs are crucial goals in today's healthcare environment. Our busy inpatient unit with a full census was leading to the overnight stays for mobilization chemotherapy taking lower priority than admissions for transplant and readmissions. Mobilization chemotherapy patients were being postponed and rescheduled to later dates and times due to a lack of inpatient beds. The constant full census and projected growth of our BMT program required a permanent solution.
**Purpose:** The goal of this project was to determine if cyclophosphamide used for mobilization could safely be administered in the outpatient setting.
**Interventions:** A multidisciplinary team including home pharmacy, nursing staff, financial coordinators, CNS and physicians gathered to brainstorm ideas to address bed utilization. Shifting cyclophosphamide mobilization to the outpatient setting appeared to be a viable solution. The potential risks and benefits of this practice shift were explored. Physician orders were modified and education was provided to the outpatient nurses. A date for go live was set for a three month trial period.
**Evaluation:** The inpatient night shift nurse phoned patients on the evening of cyclophosphamide administration to assess symptoms and symptom management. Patients completed a symptom experience survey at 24 and 48 hours post cyclophosphamide administration.
**Discussion:** Cyclophosphamide for mobilization may be given safely as an outpatient. To crucial goals of reducing costs and improving inpatient bed utilization were achieved.

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### Sustaining the Gain: A Units Quest to Maintain Significant Catheter Associated Blood Stream Infection (CA-BSI) Rate Reductions

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Healthcare reform is nationally charging patient safety initiatives including eliminating catheter associated blood stream infections (CA-BSI). Historically, a mid-west pediatric institution's highest CA-BSI rates resided on the Bone Marrow Transplant (BMT) Unit housing the most severely immune compromised patients. The complex 24 bed critical care unit performs over 90 transplants annually with over 70% being allogeneic. In 2006, BMT's CA-BSI rates reached a high of 6.35 infections per 1,000 catheter days.

Initially, a CA-BSI maintenance bundle developed in the intensive care unit was introduced. During the first year, a 32% CA-BSI rate reduction occurred.

A multidisciplinary approach utilizing quality improvement methodology was implemented. Key drivers, conditions creating the ideal state for project success, were established and guided subsequent interventions via a Plan, Do, Study, Act model. Ongoing interventions addressed unique challenges of a highly immune compromised population leading to the “Supercharged Maintenance Bundle.” formation. Over the next two years, an additional 60% rate reduction was realized leading to a 1.98 infection rate.

Further interventions generated by a national pediatric immune compromised patient focused collaborative resulted in 0.64 infections for FY11, an additional 50% two year decline.

FY12 resulted in an increased rate of 0.88 infections further challenging the quest to sustain gains and eliminate CA-BSI. Continued multidisciplinary approaches focusing on high reliability concepts are essential to sustainability. Specifically, preoccupation with failure accompanied by an in-depth infection analysis providing lessons learned help continually generate heightened awareness to those identified risk factors and associated preventative strategies. These actions lead by the bedside nurse, fuel the awareness and commitment of all caring for a highly complex and vulnerable patient population leading to the current 0.61 infections rate.

| FY | Infections per 1000 Line Days |
|---|---|
| 2005 | 5.45 |
| 2006 | 6.35 |
| 2007 | 4.83 |
| 2008 | 4.31 |
| 2009 | 1.98 |
| 2010 | 1.68 |
| 2011 | 0.64 |
| 2012 | .88 |
| Annual Cumulative | 0.61 (9/11-8/12) |

## 508

### Delivering Seamless Education throughout a Hematopoietic Progenitor Cell Transplant (HPCT) to the Patient and Caregiver

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**Objective:** A comprehensive understanding on the part of the patient undergoing an HPCT and caregiver regarding the experience during the hospitalization and the follow up care required.
**Background:** The process of HPCT can be a complex and confusing experience for a patient and their caregivers. Education is often provided in a single session when transplant is the chosen treatment. These sessions can be overwhelming and therefore much of the information is not always retained.
**Purpose:** To decrease feelings of anxiety and increase compliance by the HPCT patient in order to maintain his/her well being during the continuum of care.
**Interventions:** At NYU Langone Medical Center, the patient is given an educational document titled “Going Home After Stem Cell Transplant” by the Registered Nurse (RN) at the clinical cancer center. In collaboration with the outpatient RN, the inpatient RN continues utilizing this document once the patient is admitted. Throughout the hospitalization ample time is allotted with each patient and caregiver to discuss discharge plans. The admitting inpatient RN assesses several factors that may influence learning including language, literacy, willingness, and emotional well-being. Patients are continuously instructed at their own pace on topics pertaining to their disease process and lifestyle changes. Teaching techniques are individualized to patients and caregivers and include printed materials, verbal instruction and return demonstrations. The RN instructs the patient and caregiver to refer to the post-HPCT discharge document frequently and encourages them to ask questions as they arise.
**Evaluation:** Evaluation of the seamless education process is currently being conducted by reviewing patient satisfaction scores specific to patient education. Patients provide